State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
CN 712
TRENTON, NEW JERSEY 08625
(609) 588-2600

ALAN J. GIBBS
Commissioner

SAUL

MEDICAID COMMUNICATION NO: 92-18 **DATE:** June 3, 1992

TO: County Welfare Agency Directors

SUBJECT: Revised Fair Hearing Request

This is to advise that the prototype of the Medicaid fair hearing request, which was distributed on July 25, 1991 via Medicaid Communication No. 91-19, has been revised. A copy of the revised prototype is attached to this communication.

Note that the word "other", which was inadvertently omitted from the Fair Hearing Notice paragraph of the original prototype, has been inserted and an "s" has been added to the word "organization" in the Regarding Legal Services paragraph. Also, at the request of our Fair Hearing Unit, a space has been added on the reverse side of the prototype to indicate the appropriate county welfare agency.

If you have not already done so, please revise your agency's fair hearing request to reflect these changes. This prototype is intended to standardize the fair hearing notice/request process and should be utilized for all Medicaid dispositions.

Questions concerning this information should be directed to the field staff assigned to your county. Future requests to modify the form/process may be directed to the Office of Eligibility Policy and Operations.

Thank you for your anticipated cooperation.

Sincerely,

Saul M. Kilstein
Director

SMK:Tt
Attachment
cc: Marion E. Reitz, Dir.

To: _____ Re: _____

_____ Program: _____

_____ Case # _____

_____ Date: _____

This notification is to advise you of the following decision concerning your eligibility for the M program.

___ Eligible effective _____ ___ Terminated effective _____

___ Denied

This action has been taken because: _____

_____

This action is required by the following regulations: _____

_____

FAIR HEARING NOTICE

You have the right to request a fair hearing on this action. You must request a fair hearing wit days of the date of this letter. If you have been receiving Medicaid benefits and request a fair h within the 20-day period, your Medicaid benefits may continue until a hearing decision is reac long as you remain eligible in all other respects. **However, if the fair hearing decision is not i favor, you may be required to repay any Medicaid benefits to which you were not entitled.**

FAIR HEARING REQUEST

To request a fair hearing, complete this section in full and send a legible copy of this form to:

Division of Medical Assistance and Health Services
Fair Hearing Unit
CN-712
Trenton, New Jersey 08625

If you require assistance, please call (609)588-2655.

I want a fair hearing because: _____

_____

Only if your Medicaid benefits were terminated, check one:

___I wish to continue my Medicaid benefits.

___I do not wish to continue my Medicaid benefits.

If other than the applicant/recipi

YOUR RIGHTS

Concerning the fair hearing, you have the right to :

- Present your own case or have a relative, friend, or attorney make the presentation.

- Submit any evidence and/or bring any witnesses that bear on your case.

- Examine records or case files including the application form. You may also examine the case record in advance except for those records which are protected from release and which may not be introduced by the county welfare agency as evidence.

- Review a complete and up-to-date copy of the Medicaid Only Manual.

Regarding Legal Services

You have the right to legal counsel at your fair hearing. For individuals who cannot afford to pay for the services of an attorney, there are private legal services organizations available which provide free legal counsel.

If you wish free legal counsel, you may consult with _____

_____

If you have been denied eligibility or have had your eligibility terminated, you have the right to reapply for Medicaid benefits if there is any change in your current circumstances.

Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the grounds of race, color, national origin, age, or handicap in the administration of any program for which Federal funds are received.

_____	_____	_____
Eligibility Worker's Name	County Welfare Agency	Telephone Number

_____	_____
Eligibility Worker's Signature	Date

LD-145 (Rev. 5/92)